STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155458	A. BUILDING _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND NURSING AND REHABILITATION CENTER	9630 FIFTH ST HIGHLAND, IN 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00202538 completed on June 15, 2016. This visit was in conjunction with the PSR to the Recertification and State Licensure Survey completed on July 15, 2016. This visit was in conjunction with the Investigation of Complaints IN00208976 and IN00209286. Complaint IN00202538 - corrected. Survey dates: September 8 & 9, 2016 Facility number: 000367 Provider number: 155458 AIM number: 100289280 Census bed type: SNF/NF: 30 Total: 30 Census payor type: Medicare: 2 Medicaid: 20 Other: 8 Total: 30 Sample: 19 Highland Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B, and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00202538.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND NURSING AND REHABILITATION CENTER	9630 FIFTH ST HIGHLAND, IN 46322

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{F 000}	Continued From page 1 Quality review completed by 32883 on 9/12/16.	{F 000}		